STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/12/17 through 9/13/17. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 87 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents #1through #15) and 4 closed record review (Residents # 15 through #19).	F 000		
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		10/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/27/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to notify physician of blood sugars outside of established parameters for 1 of 19 residents (Resident #1). The findings included: The facility staff failed to notify physician of blood sugars outside of established parameters for 9 out of 12 days in the month of September, 2017.	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 157	Continued From page 2	F 157		

Resident #1 was readmitted to the facility on 9/19/16 with the following diagnoses of, but not limited to diabetes, hypokalemia, adult failure to thrive, high blood pressure, dementia, anxiety disorder and Parkinson's disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/6/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing.

A clinical record review was performed by the surveyor on 9/12/17. It was noted by the surveyor that Resident #1 had the following order from the physician:
" ...Novolog ...Inject 8 units subcutaneously before meals for DM (Diabetes Mellitus) May hold if BS (blood sugar) below 100 - Notify MD (medical doctor) ..." The MAR (Medication Administration Record) was also reviewed by the surveyor for the month of September, 2017. The following dates and times were times that blood sugars were outside of established parameters as documented above:

- o 9/2/17 0730 (7:30 am) Blood Sugar 96
- o 9/3/17 0730 Blood Sugar 82
- o 9/4/17 0730 Blood Sugar 77
- o 9/5/17 0730 Blood Sugar 93
- o 9/5/17 1600 (4:00 pm) Blood Sugar 74
- o 9/7/17 0730 Blood Sugar 84
- o 9/8/17 0730 Blood Sugar 61
- o 9/9/17 0730 Blood Sugar 90
- o 9/10/17 0730 Blood Sugar 62
- o 9/11/17 0730 Blood Sugar 87

For the times and dates listed above that the deficiencies cited have been or will be completed by the dates indicated.

F157
1. For resident #1, the primary physician was notified 9/12/17 of blood glucose readings on
9/2, 9/3, 9/4, 9/5, 9/7, 9/8, 9/9, 9/10, 9/11 .
2. Current residents requiring monitoring of blood glucose are at risk.
3. SDC or designee will educate licensed nursing staff on physician notification of blood glucose readings that fall outside of the ordered parameters.
4. Audit of current residents with blood glucose monitoring to identify those with parameters completed 9/12/17. DON or designee will audit medication administration records for those residents with parameters weekly for four weeks with the findings reviewed in the next quarterly QA meeting.

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F 157	Continued From page 3 resident's blood sugar was documented below 100, the surveyor noted that the insulin was administrated and not held and the physician was not notified of the blood sugars below 100 as the above documented order had stated. At 4:40 pm on 9/12/17, the corporate nurse brought copies of the resident's nursing notes, MAR and physician orders for September, 2017 to the surveyor in the conference room. The corporate nurse stated to the surveyor that she had reviewed the copies and did not see where the physician had been notified or the insulin held for the blood sugars that were below 100. On 9/13/17 at 1 pm, the surveyor notified the administrative team of the above documented findings for Resident #1. The surveyor requested a copy of the facility's policy on notifying the physician of blood sugars that are outside of established parameters. At 4 pm, the surveyor received a copy of the facility's policy titled "Blood Testing" from unit manager #1. Under the Procedure section of the policy it read in part " ...5. Emergency readings as well as blood glucose results that are outside of the ordered parameters are to be communicated to the physician, as directed ..." No further information was provided to the surveyor prior to the exit conference on 9/13/17.	F 157		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing,	F 252		10/10/17

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F 252	Continued From page 4 as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain a clean, comfortable and homelike environment for 2 of 3 shower rooms. The findings included: For one of two shower rooms on Unit 1 of the facility the staff failed to ensure the shower curtain was clean and for the shower room on Unit 2 of the facility the staff failed to ensure the shower room was odor free. The surveyor observed the rehab shower room on Unit 1 of the facility on 09/12/17 at	F 252	F 252 1. The shower curtain on Unit one was replaced on 9/12/17. The shower room on Unit two was cleaned again as well. The exhaust system was inspected and noted not to be properly circulating the air in the room. This was corrected by maintenance on 9/19/17. 2. Current residents are at risk. 3. SDC or designee will educate nursing and housekeeping staff on keeping shower rooms clean and odor free. 4. DON or designee will make daily rounds of the shower rooms daily for two weeks to ensure they are kept clean and	

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F 252	Continued From page 5 approximately 1325. The shower curtain in this shower room had a dark blackish stain across the bottom of the curtain which resembled mildew. The surveyor observed the shower room on Unit 2 of the facility on 09/12/17 at approximately 1455. The shower room had a strong odor of urine. The surveyor observed the shower room on Unit 1 again on 09/13/17. The same shower curtain with the blackish stain was again observed. The surveyor observed the shower room on Unit 2 again on 09/13/17 at approximately 0930. There was still a strong odor of urine noted. The surveyor made a general tour of the facility with the maintenance director on 09/13/17 at approximately 1430. The surveyor and the maintenance director observed the shower room on Unit 1 of the facility. Surveyor pointed out the stained shower curtain and the maintenance director stated the he would have the shower curtain replaced. The surveyor and the maintenance director observed the shower room on Unit 2 of the facility. The maintenance director stated the the room smelled "musty". As the surveyor and the maintenance director exited the shower room, CNA #1 was standing in the hallway outside of the shower room and stated "Yeah, it stinks in there". The concern of the stained shower curtain and the odor in the shower room was discussed with the administrative team during a meeting on 09/13/17 at approximately 1605. The administrator and the corporate compliance nurse stated that they had checked the shower room on	F 252	odor free. Housekeeping Director will ensure shower room are detail cleaned monthly. 5. Results of audits will be reported to the QA Committee during the next quarterly meeting.	

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F 252	Continued From page 6 Unit 2 and they did not detect any urine odor. Administrator also stated that the shower curtain in question was supposed to be "mildew resistant. No further information was provided prior to exit.	F 252		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%. There were 2 errors out of 25 opportunities for a medication error rate of 8% that affected 1 of 19 residents in the survey sample. (Resident #12) The findings included: Resident #12 was admitted to the facility on 9/10/17 with the following diagnoses of, but not limited to muscle weakness, anxiety disorder, hypothyroidism, high blood pressure and peripheral vascular disease. The 14 day admission MDS (Minimum Data Set) had not been completed at this time. According to the nursing assessment of the resident on admission to the facility on 9/10/17, the resident was alert and oriented to place and person. Resident #12 also required assistance of 2 staff members to be up and out of bed.	F 332	F332 1. The physician was notified of resident # 12 receiving the crushed medications on 9/13/17. Resident did not experience any untoward event due to the practice. 2. Current residents with a need for crushed medications are at risk. 3. SDC or designee to educate licensed nursing staff regarding medications that cannot safely be crushed. 4. DON or designee will perform med pass observations with licensed staff weekly for four weeks to ensure proper crushing of medications. Results of audits will be reported to the Q.A. committee during quarterly meetings.	10/10/17

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F 332	Continued From page 7	F 332		

During the medication pass and pour observation made by the surveyor on 9/13/17 at 8:20 am, LPN (Licensed Practical Nurse) #1 was observed to crush the following medications and administer these medications in applesauce to Resident #12: "Aspirin 81 mg (milligram) EC (Enteric Coated) 1 tablet and Ferrous Sulfate 325 mg (Iron 65 mg) 1 tablet." As LPN #1 was crushing the above documented medications, LPN #1stated to the surveyor, "I don't know if I should crush all of these or not."

At 10:15 am, Unit manager #1 was notified of the above observation made by the surveyor during the medication pass and pour. The surveyor asked unit manager #1 if Aspirin Enteric Coated and Iron tablets could be crushed and then administrated these to the resident. Unit manager #1 stated "No, they shouldn't. The nurses have a do not crush list in the front of the notebook on each medication cart if they are unsure." The surveyor asked for a copy of the Do Not Crush list of medications that the unit manager was referring to.

At 11 am on 9/13/17, unit manager #1 provided a copy of the facility's "Common Oral Dosage Forms That Should Not Be Crushed" to the surveyor in the conference room. The surveyor reviewed the list provided and noted that the 2 following medications were listed on this do not crush list: Aspirin Enteric Coated and Ferrous Sulfate. These were the 2 medications that the surveyor observed LPN #1 crushing during the medication pass and pour observation and administered to Resident #12.

At 2:45 pm, the clinical record review was

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F 332	Continued From page 8 completed by the surveyor for Resident #12. The surveyor noted a physician order dated for 9/10/17 which stated "May crush medications ..." At 1 pm, the administrative team was notified of the above documented observations and findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 9/13/17.	F 332		
F 333 SS=E	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to prevent a significant medication error in 1 of 19 residents in the survey sample (Resident #1). The findings included: The facility staff failed to hold Resident #1's insulin according to blood sugars that were obtained as ordered by the physician for 9 out of 12 days in the month of September, 2017. Resident #1 was readmitted to the facility on 9/19/16 with the following diagnoses of, but not limited to diabetes, hypokalemia, adult failure to thrive, high blood pressure, dementia, anxiety	F 333	F333 1. Resident #1□s physician was notified of insulin being administered outside of parameters on 9/12/13. Resident did not suffer any untoward events due to the practice. 2. Current residents with parameters for insulin are at risk. 3. SDC or designee to provide licensed staff with education of holding insulin if blood glucose is outside of ordered parameters. 4. DON or designee will audit medication administration records for those residents weekly for four weeks and findings will be reported to the QA committee during the	10/10/17

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F 333	Continued From page 9	F 333		

disorder and Parkinson's disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/6/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing.

A clinical record review was performed by the surveyor on 9/12/17. It was noted by the surveyor that Resident #1 had the following order from the physician:
" ...Novolog ...Inject 8 units subcutaneously before meals for DM (Diabetes Mellitus) May hold if BS (blood sugar) below 100 - Notify MD (medical doctor) ..." The MAR (Medication Administration Record) was also reviewed by the surveyor for the month of September, 2017. The following dates and times were times that blood sugars were outside of established parameters as documented above:
" 9/2/17 0730 (7:30 am) Blood Sugar 96
" 9/3/17 0730 Blood Sugar 82
" 9/4/17 0730 Blood Sugar 77
" 9/5/17 0730 Blood Sugar 93
" 9/5/17 1600 (4:00 pm) Blood Sugar 74
" 9/7/17 0730 Blood Sugar 84
" 9/8/17 0730 Blood Sugar 61
" 9/9/17 0730 Blood Sugar 90
" 9/10/17 0730 Blood Sugar 62
" 9/11/17 0730 Blood Sugar 87
For the times and dates listed above that the resident's blood sugar was documented below 100, the surveyor noted that the insulin was administrated and not held and the physician was not notified of the blood sugars below 100 as the above documented order had stated.

next quarterly meeting.

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F 333	Continued From page 10 At 4:40 pm on 9/12/17, the corporate nurse brought copies of the resident's nursing notes, MAR and physician orders for September, 2017 to the surveyor in the conference room. The corporate nurse stated to the surveyor that she had reviewed the copies and did not see where the physician had been notified or the insulin held for the blood sugars that were below 100. On 9/13/17 at 1 pm, the surveyor notified the administrative team of the above documented findings for Resident #1. The surveyor requested a copy of the facility's policy on notifying the physician of blood sugars that are outside of established parameters. At 4 pm, the surveyor received a copy of the facility's policy titled "Blood Testing" from unit manager #1. Under the Procedure section of the policy it read in part " ...5. Emergency readings as well as blood glucose results that are outside of the ordered parameters are to be communicated to the physician, as directed ..." No further information was provided to the surveyor prior to the exit conference on 9/13/17.	F 333		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 425		10/10/17

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F 425	Continued From page 11 employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to 2 of 19 residents in the survey sample (Resident #8 and #13). The findings included: 1. The facility staff failed to ensure that Resident #8 had the medication, Macrobid, available for administration on 6/15/17 at 0900 as ordered by the physician. Resident #8 was readmitted to the facility on 12/4/16 with the following diagnoses of, but not limited to depression, anemia, coronary artery disease, urinary tract infection, heart failure, high blood pressure, dementia, seizure disorder and anxiety disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/28/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance of 1 staff member for eating, dressing and personal hygiene. A clinical record review was performed on Resident #8's clinical record on 9/12/17 by the surveyor. The surveyor noted on the June, 2017 MAR (Medication Administration Record) that the following medication was documented as a "9"	F 425	F425 1. Physician for residents # 8 and # 13 were notified of medications documented as unavailable with no new orders obtained. 2. Current residents are at risk to be affected. 3. SDC or designee to educate licensed staff on obtaining and administering medications in a timely fashion, including use of stat box and back up pharmacy. 4. DON or designee will audit nurses notes and medication administration records daily for two weeks and the results will be reported to the QA committee at the next quarterly meeting.	

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and according to the key, this represents that the reviewer would need to "See the Progress Notes." The medication was for "Macrobid Capsule 100 mg (milligram) ...Give 1 capsule by mouth two times a day for a fever until 6/15/17 2359 (11:59 pm) ."

The surveyor reviewed the nursing notes for 6/15 17 and it read in part ..."medication unavailable from pharmacy ..."

The administrative team was notified of the above documented findings on 9/13/17 at 1 pm by the surveyor in the conference room.

No further information was provided to the surveyor prior to the exit conference on 9/13/17.

2. The facility staff failed to ensure, Lovenox, a blood thinner, was available for administration to Resident #13.

Resident #13 was admitted to the facility on 9/8/17 with the following diagnoses of, but not limited to contusion and laceration of cerebrum, traumatic subarachnoid hemorrhage, injury of the left kidney and fractures to the pelvic region, right arm and right acetabulum. The 14 day admission MDS (Minimum Data Set) was in progress in being completed at the time of the clinical record review.

The surveyor noted that on 9/817 at 20:36 (10:36 pm) the following documentation was made in the nurses' notes which stated "Lovenox Solution 40 mg (milligram)/0.4 ml (milliliter) ...Medication no available from pharm (pharmacy), MD (Medical Doctor) notified, RP (responsible party) notified, and medication to be delivered on next delivery."

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F 425	Continued From page 13 According to the Medication Administration Record for Resident #13, this medication was scheduled to be administered on 9/8/17 at 2100 (9:00 pm). The surveyor asked LPN (Licensed Practical Nurse) #2 at 2:50 pm to provide a copy of the Stat Box contents. LPN #2 returned to the surveyor with a copy of the contents of the Stat Box. The surveyor reviewed the contents list and noted that "Lovenox 100 mg 4 syringes" were available for the staff. RN (Registered Nurse) #1 was asked what the staff was to do in the case of a medication being unavailable to administer as order to the resident y the surveyor. RN #1 stated "They are to check the Stat Box to see if the medication is in there, if so go through the proper channels to obtain the medication and administer it to the resident. If the medication is not in the Stat Box, they are to notify the doctor and receive an order on what to do until the medication is available from pharmacy to give." The administrative staff was notified of the above documented findings on 9/13/17 at 4 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 9/13/17.	F 425		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		10/10/17

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F 441	Continued From page 14 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 441		

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F 441	Continued From page 15 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, the facility staff failed to maintain tracking inforation related to infection control and failed to ensure an effective infection control program for 2 of 19 residents (Residents #4 and 12). The findings included: 1.During the entrance conference on 9/12/17, the surveyor requested the infection control line list (tracking form for facility infections) for the past year from the administrator. When the infection control line listing was provided to the surveyor by the current infection control nurse RN #1, it was incomplete for several months. The line lisiting titled monthly infection	F 441	F 441 1. For resident #4, the staff immediately replaced the sign for precautions when it was identified as missing from the door. Resident # 12 had no untoward effects related to the event. 2. Current residents are at risk. 3. SDC or designee to educate nursing staff on: a. Ensuring proper signage is in place for residents with transmission based precautions. b. Hand washing procedure during medication pass. 4. DON or designee will: a. perform random med pass observations with licensed staff weekly for four weeks to ensure proper hand	

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F 441	Continued From page 16 control surveillance information. The surveyor showed the infection control nurse that the results from 11/1/16 until 7/1/17 did not indicate the infections had been resolved or were ongoing and the record was incomplete. The infection control information form was complete from July through August, 2017 when RN #1 became the infection control nurse. The surveyor requested the facility infection control policy on 9/13/17. The infection control policy and procedure provided on 9/13 /17 to the surveyor did not list information related to the tracking of infections. The policy provided was named: "Transmission Based Precautions". The surveyor informed the administrator and the regional nurse consultant, of the incomplete line list finding on 9/13/16. No further information was provided prior to the exit conference on 9/13/17. 2. For Resident #4, the facility staff failed to notify the surveyor and/or post door signage to inform the staff and/or any visitors of the need for contact precautions when entering the resident's room. This resulted in the surveyor entering the Residents room without any PPE (personal protective equipment). The record review revealed that Resident #4 had been admitted to the facility 08/05/17. Diagnoses included, but were not limited to, MRSA (methicillin resistant staphylococcus aureus) infection, chronic multifocal osteomyelitis, chronic kidney disease, type 2 diabetes, chronic pain syndrome, and peripheral vascular disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment	F 441	washing. Results of audits will be reported to the Q.A. committee during quarterly meetings. b. Perform daily rounds for two weeks to ensure residents with precautions in place have the proper sign posted, results to be reported to the QA committee during the next quarterly meeting.	

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with an ARD (assessment reference date) of 08/12/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) was coded to indicate the Resident had a MDRO (multidrug resistant organism).

The Residents CCP (comprehensive care plan) included the focus areas-
"The resident has non-pressure related potential /actual impairment to skin integrity of the left heel r/t (related to) infection MRSA."
"The resident has infection of the left heel (MRSA). Contact precautions in place. IV antibiotics via PICC line." Interventions included "...precautions (specify) as ordered..."

The Residents clinical record included a physicians order dated 08/05/17 for "contact precautions r/t MRSA."

During initial tour of the facility on 09/12/17 at approximately 10:45 a.m. the surveyor approached Resident #4's room accompanied by the unit manager. After obtaining information from the unit manager regarding the two Residents in this room the surveyor entered the room and spoke with Resident #4 and her roommate. Upon exiting the room the surveyor observed a yellow bag stocked with supplies on the open door. The surveyor asked the unit manager if one of the Residents in this room were on isolation to which the unit manager replied yes and identified Resident #4 as the Resident on isolation. When asked about signage and the Residents isolation status the unit manger verbalized to the surveyor that there was no signage on the door. The unit manager did not share with the surveyor that Resident #4 was on contact precautions prior to

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the surveyor entering the Residents room and allowed the surveyor to enter the room without any PPE in place. The Residents isolation status was only shared with the surveyor when the unit manager was specifically asked if a Resident in this room was on isolation.

On 09/12/17 at approximately 11:20 a.m. the surveyor interviewed the designated infection control nurse regarding the lack of signage outside Resident #4's door. The surveyor and the infection control nurse walked to the Residents room and it was observed that the facility staff had attached a sign to the yellow bag hanging on the door that would alert staff and/or visitors that the Resident was on contact precautions. When asked if the sign should have been posted prior to the surveyor inquiring about it. The infection control nurse verbalized to the surveyor that there should have been a sign in place.

On 09/12/17 at approximately 11:40 a.m. the infection control nurse provided the facility with their policy/procedure titled "Transmission Based Precautions." This policy/procedure read in part "...Contact Precautions...Wear gloves when entering room and whenever touching the patient's intact skin, surfaces or articles in close proximity..."

The administrator was notified of the above on 09/12/17 at approximately 3:40 p.m.

On 09/13/17 the facility provided the survey team with a typed letter dated 09/13/17 that had been signed by LPN (licensed practical nurse) #4. That read "On September 12, 2017 I was providing care for _____ (name omitted) when I noticed she had something tucked inside her pants and it

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was folded and orange, when I went to look the resident stated "Those are mine, I need to hang my pictures up" she was referring to 2 orange contact precaution signs. I removed them and sanitized them with purple antiseptic wipes allowed them to dry before placing them where they belonged."

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. The facility staff failed to follow infection control guidelines regarding hand washing during the medication pass and pour observation made by the surveyor with Resident #12.

Resident #12 was admitted to the facility on 9/10/17 with the following diagnoses of, but not limited to muscle weakness, anxiety disorder, hypothyroidism, high blood pressure and peripheral vascular disease. The 14 day admission MDS (Minimum Data Set) had not been completed at this time. According to the nursing assessment of the resident on admission to the facility on 9/10/17, the resident was alert and oriented to place and person. Resident #12 also required assistance of 2 staff members in getting out of bed.

During the medication pass and pour observation on 9/13/17 at 8:20 am, LPN (Licensed Practical Nurse) #1 was observed by the surveyor to prepare and administer medications as ordered to Resident #12. The LPN was observed not to have used hand sanitizer or wash her hands after administering medications to another resident before the medications were prepared for Resident #12 and administering the medication to Resident #12. LPN #1 was observed by the

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surveyor to wash her hands after the medications were given to Resident #12 before she left the resident's room.

At 10:15 am, unit manager #1 was notified of the above documented observations of LPN #1 not washing her hands between residents when administering medications. The surveyor asked unit manager #1 when the staff should wash their hands and she stated "Before and after administering medications to the residents or when visibly soiled."

The administrative team was notified on 9/13/17 at 1 pm of the above documented findings and observations made by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 9/13/17.